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| 8 | BEFORE THE | |
| 9 | BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS | |
| 10 | STATE OF CALIFORNIA | |
| 11 | In the Matter of the Accusation Against: | Case No. 2013-500 |
| 12 | NERIDA JANE ANDERSON | |
| 13 | 200 Coggins Drive, Apt. 15 Pleasant Hill, CA 94523 | ACCUSATION |
| 14 | Registered Nurse License No. 645626 | |
| 15 | Respondent. | |
| 16 | | |
| 17 | Complainant alleges: | |
| 18 | <u>PARTIES</u> | |
| 19 | 1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her | |
| 20 | 1. Louise R. Barley, W.Ed., Riv (Comp. | amant) orings this Accusation solery in her |
| - 1 | official capacity as the Executive Officer of the E | |
| 21 | | |
| 21 22 | official capacity as the Executive Officer of the E Consumer Affairs. | Board of Registered Nursing, Department of |
| | official capacity as the Executive Officer of the E Consumer Affairs. | Board of Registered Nursing, Department of Board of Registered Nursing issued Registered |
| 22 | official capacity as the Executive Officer of the E Consumer Affairs. 2. On or about September 29, 2004, the | Board of Registered Nursing, Department of Board of Registered Nursing issued Registered anderson (Respondent). The Registered Nurse |
| 22 23 | official capacity as the Executive Officer of the E Consumer Affairs. 2. On or about September 29, 2004, the Nurse License Number 645626 to Nerida Jane An | Board of Registered Nursing, Department of Board of Registered Nursing issued Registered anderson (Respondent). The Registered Nurse |
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| 22 23 24 25 | official capacity as the Executive Officer of the E Consumer Affairs. 2. On or about September 29, 2004, the Nurse License Number 645626 to Nerida Jane An License was in full force and effect and expired of | Board of Registered Nursing, Department of Board of Registered Nursing issued Registered anderson (Respondent). The Registered Nurse |
| 22 23 24 25 26 | official capacity as the Executive Officer of the E Consumer Affairs. 2. On or about September 29, 2004, the Nurse License Number 645626 to Nerida Jane An License was in full force and effect and expired of | Board of Registered Nursing, Department of Board of Registered Nursing issued Registered anderson (Respondent). The Registered Nurse |

JURISDICTION

- 3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.
- 4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.
- 5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811(b), the Board may renew an expired license at any time within eight years after the expiration.

STATUTORY PROVISIONS

- 6. Code section 490 provides, in pertinent part, that a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.
 - 7. Code section 2761 states, in part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct, which includes, but is not limited to, the following:
- (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

REGULATORY PROVISIONS

8. California Code of Regulations, title 16, section 1442, states:

As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTUAL STATEMENT

- 10. From on or about January 9, 2006 through November 14, 2008, Kaiser Permanente San Francisco Medical Center (Kaiser) in San Francisco, California employed Respondent as a registered nurse.
- 11. On or about October 24, 2008, Kaiser assigned Respondent to care for Patient A and Patient B in the Intensive Care Unit (ICU).
- 12. Patient A¹ suffered from diabetic ketoacidosis (a life-threatening complication from diabetes that is monitored through blood tests) and his doctor ordered Respondent to draw the patient's blood every two hours to test electrolyte levels. At approximately 1700 hours, Respondent yelled "I don't understand why we have to do these checks every two hours," "I don't understand why we cannot do it every four hours, and "I'm not going to do it." Respondent continued to yell.
- 13. Patient B was a cardiac patient with a history of pulling his oxygen mask off because it was uncomfortable. Respondent told Patient B "you better keep your mask on or I'm going to restrain you" and "you had better keep your mask on." She shook her fist at him. Respondent told a first year resident physician that Patient B required restraint and obtained an order to restrain him. Patient B was alert and oriented. He objected to being placed in restraints. Respondent administered morphine to Patient B for his "comfort." Dr. Mirwis Amoni released Patient B from the restraints and asked Respondent not to restrain Patient B. Patient B reported that Respondent was mean to him, tied him to the bed, and hit his face a couple of times. Patient

¹ Patients are identified by letters in order to protect the patients' confidentiality. The full names of the patients will be disclosed pursuant to a request for discovery.

B asked that Respondent not care for him. Respondent yelled at Dr. Amoni "You take care of him. You do it. I am not going to."

- 14. Shortly thereafter, Respondent left the ICU. She did not state that she was taking a break. Later, Respondent returned to the ICU shouted expletives about and to Dr. Amoni.
 - 15. On or about November 14, 2008, Kaiser terminated Respondent.
- 16. During an unknown period of time that included October 7, 2009, Alameda Medical Center in Oakland, California, employed Respondent as a registered nurse through a nurse registry.
- 17. Patient C was admitted to Alameda Medical Center for shortness of breath and seizures. On or about October 7, 2009, Respondent treated Patient C. Physician's orders dated October 7, 2009, stated that "after checking Dilantin level, give one gram Dilantin over one hour IV, don't push quickly." At approximately 2155 hours, Respondent administered one gram of Dilantin to Patient C during a five-minute period. At approximately 2201 hours, Patient C became bradycardic and, at approximately 2240 hours, died from the rapid infusion of Dilantin.
- 18. On an unknown date on or about October 7, 2009, Alameda Medical Center placed Respondent on the "Do Not Return" list, prohibiting Respondent from working at Alameda Medical Center in the future.

CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

- 19. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for unprofessional conduct, as defined by California Code of Regulations, title 16, section 1442, in that she committed acts of gross negligence in carrying out her usual certified or licensed nursing functions.
- 20. On or about October 24, 2008, as more particularly set forth in paragraphs 10 through 15, above, she committed the following acts of gross negligence:
 - a. Failed to administer safe and judicious care to Patient A and Patient B; and
- b. Failed to conduct herself in a professional manner while caring for critically ill patients.